

Evidence for addition
in #18' shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH
FILE No. G 130 JAN 19 1951

Reg. Dist. No. 92

1. PLACE OF DEATH- COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Elkton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Chesapeake City</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Union Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>CHARLES ALBERT BEISWANGER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 14</u> 19 <u>51</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>Wh.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct 15, 1881</u>
9. AGE last birthday <u>69</u> yrs.		10. a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Storekeeper</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Store (Confectionary)</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>John Beiswanger</u>	
14. MOTHER'S MAIDEN NAME <u>No Inf.</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY No. (If year, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Mrs. Rena Beiswanger, Ches City, Md</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
442x Immediate cause (a) <u>Cerebrovascular vessel disease</u>		<u>2 years</u>
Antecedent cause(s) (b) <u>Pleural effusion</u>		<u>unknown</u>
13/a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Cause unknown: Culture of effusion negative for all bacteria</u>		<u>(1/22/51 also)</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan 6, 1951, to Jan 14, 1951, that I last saw the deceased alive on Jan 14, 1951, and that death occurred at 12:01 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

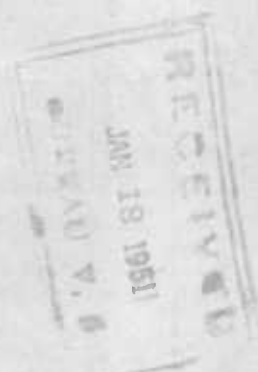
23. BURIAL, CREMATION REMOVAL (Specify)		DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>		<u>Jan 17/51</u>	<u>Bethel</u>	<u>New Chesapeake City</u>	<u>Md</u>
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
<u>Jan 16</u>		<u>H. Strazzer</u>		<u>R. W. Kippin & Son, Elkton, Md</u>	

290417

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>CECIL</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CEILTON</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CECILTON</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>JOHN</u>	(Middle) <u>-</u>	(Last) <u>BENSON</u>
4. DATE OF DEATH	(Month) <u>1</u>	(Day) <u>10</u>	(Year) <u>1957</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>APR 12 1878</u>
9. AGE last birthday <u>72</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GROCCER</u>	11. BIRTHPLACE (State or foreign country) <u>EARLVILLE Md</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>JOHN S. BENSON</u>		14. MOTHER'S MAIDEN NAME <u>MARY DENNEY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>Mrs John Benson, Ceilton, Md</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Massive Cerebral Hemorrhage</u>		<u>3 hours</u>
443X Antecedent cause(s)	(b) <u>Hypertension Cardiovascular disease</u>		<u>10 years</u>
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 15, 1940 to Jan 10, 1951, that I last saw the deceased alive on Jan 10, 1951, and that death occurred at 4:10 P.M., from the causes and on the date stated above.

SIGNATURE <u>[Signature]</u>	DATE <u>Jan 13 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Cecilton Ceil</u>	LOCATION (City, town, or county) (State) <u>Cecilton Ceil Md</u>
DATE REC'D BY LOCAL REG. <u>Jan 11</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>Joseph R. Frank, North East Md</u>	ADDRESS <u>290 636</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 12 1951
READ A. V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

0390

1. PLACE OF DEATH- COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Harford	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Perry Point		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Aberdeen	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration		STREET ADDRESS (If rural, give location) 15 Rigdon Road	
3. NAME OF DECEASED (First) ROBERT (Middle) S. (Last) BROWN		4. DATE OF DEATH January 22, 19 51	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 8-29-1892
9. AGE last birthday 58 yrs.		10. BIRTHPLACE (State or foreign country) Washingtonville, Penna.	
11. FATHER'S NAME Louis Brown - deceased		12. CITIZEN OF WHAT COUNTRY? USA	
13. MOTHER'S MAIDEN NAME Amanda Hibshman - deceased		14. INFORMANT AND ADDRESS Hospital records	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown	

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Coronary thrombosis due to	Unknown
Antecedent cause(s) (b) Coronary sclerosis	
(c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work Not While at work
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Dec. 30, 1950, to Jan. 22, 1951, and that death occurred at 9:45 PM m., from the causes and on the date stated above.

SIGNATURE E. P. BRANNON, M.D., Chief, Professional Services, VAH, Perry Point, Md. DATE SIGNED Jan. 23, 1951

23. BURIAL, CREMATION REMOVAL (Specify) Removal	DATE THEREOF 1-23-51	NAME OF CEMETERY OR CREMATORY Unknown	LOCATION (City, town, or county) (State) Aberdeen, Maryland
DATE REC'D BY LOCAL REG. Jan. 23, 1951	REGISTRAR'S SIGNATURE Irene S. Doughty	24. FUNERAL DIRECTOR HENRY TARRING & SONS, ABERDEEN, MARYLAND	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH- COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>St. Mary's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>St. Inigoes</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>		STREET ADDRESS (If rural, give location) <u>RFD</u>	
3. NAME OF DECEASED (First) <u>HARRY</u> (Middle) <u>J.</u> (Last) <u>CHISLEY</u>		4. DATE OF DEATH (Month) <u>January</u> (Day) <u>27</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>6-24-90</u>
9. AGE last birthday <u>60</u> yrs.		10. If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Chisley</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Hospital Records, VAH, Perry Point, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) <u>Adenocarcinoma of large bowel.</u>		<u>Unknown</u>
(b) <u>Generalized carcinomatosis of peritoneal cavity.</u>		<u>Unknown</u>
(c) <u> </u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION <u>1-15-51</u>		19b. MAJOR FINDINGS OF OPERATION <u>Iliostomy (see above)</u>		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u> </u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u> </u>		(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u> </u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR? <u> </u>

22. I hereby certify that I attended the deceased from 12-29, 1950, to 1-27, 1951, and that death occurred at 11:15 A. (Degree or title) ADDRESS DATE SIGNED

E. P. BRANNON, M.D., Chief, Professional Services VAH, Perry Point, Md. Jan. 27, 1951	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u>	DATE THEREOF <u>1-29-51</u>
NAME OF CEMETERY <u>St. Peter Claver's Church</u>	
LOCATION (City, town, or county) (State) <u>Ridge, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>Jan. 29, 1951</u>	24. FUNERAL DIRECTOR <u>PENNINGTON & SON, Havre de Grace, Md.</u>

MARGIN RESERVED FOR BINDING

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 30 1951
U.S. DEPT. OF AGRICULTURE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *92*

1. PLACE OF DEATH COUNTY <i>Cecil</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Md.</i> COUNTY <i>Kent</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Eckton</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Eckton</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Union Hospital</i>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <i>CARROLL</i> (First) <i>Everness</i> (Middle) <i>Christy</i> (Last)		4. DATE OF DEATH (Month) <i>1</i> (Day) <i>14</i> (Year) <i>1957</i>	
5. SEX <i>F.</i> COLOR OR RACE <i>E</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Single</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Practical Nurse</i>		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <i>Elgie Christy Jr.</i>		14. MOTHER'S MAIDEN NAME <i>Naomi - Brown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <i>Elgie Christy Falk Md.</i>		12. CITIZEN OF WHAT COUNTRY?	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <i>Premature 28 weeks.</i>			
Antecedent cause(s) (b) <i>176x</i>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <i>159</i>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
SUICIDE		INJURY	
HOMICIDE		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *12/25*, 19*50*, to *1-14*, 19*57*, that I last saw the deceased alive on *1-14*, 19*57*, and that death occurred at *1250P* m., from the causes and on the date stated above.

SIGNATURE *Edith Dodson MD* (Degree or title) ADDRESS *Rising Sun Md* DATE SIGNED *1-14-57*

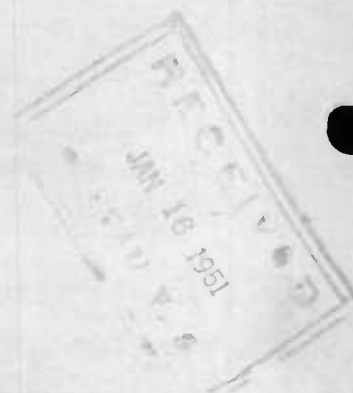
23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<i>Buried</i>	<i>Jan 16/50</i>	<i>Lawson Cem.</i>	<i>Lawson Md.</i>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<i>Jan 15</i>	<i>Edith Dodson</i>	<i>Edith Dodson</i>	<i>Edith Dodson Millington Md.</i>

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0393

1. PLACE OF DEATH COUNTY Cecil		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rising Sun Rural		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Elkton Rural	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Graybeal Nursing Home		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)	(First) David	(Middle) Samuel	(Last) Cline
4. DATE OF DEATH	(Month) Jan	(Day) 12	(Year) 1951
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Jan. 26, 1867
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner	9. AGE last birthday 83 yrs.
11. BIRTHPLACE (State or foreign country) Wytheville Va.		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No.	
17. INFORMANT Burnard Cline			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
450.0 Immediate cause (a) Chronic hepatitis			
131a Antecedent cause(s) (b) arteriosclerosis			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 9-1-1950, to 1-12-1951, that I last saw the deceased alive on 1-9-1951, and that death occurred at 7 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

W. D. Doctor M.D. Rising Sun Md. 1-13-51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Jan 15, 1951	Brookview Cem.	Rising Sun, MD.	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
Jan 13-1951	L. M. Worthington	J. C. Tyson	Rising Sun, Md.	

100105

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

January 16, 1951

Dear Sir:

I have your letter of January 11, 1951, regarding the matter of the proposed amendment to the Federal Food, Drug, and Cosmetic Act, which would require the labeling of certain foods with the name of the manufacturer.

The Department is currently studying this proposal and will advise you of the results of its consideration as soon as possible.

Very truly yours,

W. L. RORER, Secretary

RECEIVED
JAN 16 1951
U. S. DEPT. OF AGRICULTURE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH- COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE NEW YORK COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Perry Point		CITY (If outside corporate limits, write RURAL and give nearest town) NEW YORK	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration		STREET ADDRESS (If rural, give location) 2460 Davidson Avenue	
3. NAME OF DECEASED (First) JAMES (Middle) A. (Last) CONNELLY		4. DATE OF DEATH (Month) January (Day) 15 (Year) 19 51	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 12-23-1897
9. AGE last birthday 53 yrs.		10. CITIZEN OF WHAT COUNTRY USA	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		11b. KIND OF BUSINESS OR INDUSTRY --	
12. FATHER'S NAME JAMES CONNELLY - deceased		13. MOTHER'S MAIDEN NAME MARGARET FLYNN	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		15. SOCIAL SECURITY No. 186-01-6324	
16. INFORMANT AND ADDRESS Hospital Records			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **Carcinoma of the liver, primary bile duct type**

INTERVAL BETWEEN ONSET AND DEATH

Unknown

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Dec. 1, 19 50** to **Jan. 15, 19 51**and that death occurred at **3:25 AM**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

E. F. BRANNON, M.D., Chief, Professional Services, VAH, Perry Point, Md. 1-17-51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

PENNINGTON & SON, Havre de Grace, Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE DISTRICT OF COLUMBIA COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Perry Point		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital		STREET ADDRESS (If rural, give location) 1336 Quincy Street, N.W.	
3. NAME OF DECEASED (Type or Print) WILLIAM E. COONEY		4. DATE OF DEATH (Month) January (Day) 23 (Year) 1951	
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH 8-30-1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	9. AGE last birthday 64 yrs. If under 1 year Months. Days Hours Min.
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM F. COONEY		14. MOTHER'S MAIDEN NAME NORA FEELEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If year, give war or dates of service) WW-1		16. SOCIAL SECURITY No. Unknown	
17. INFORMANT AND ADDRESS Hospital Records, VAH., Perry Point, Md.			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Pneumonia, bronchial, bilateral			Approx. 1 week
Antecedent cause(s) (b) Carcinoma, pancreas, primary			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION 8-14-50	19b. MAJOR FINDINGS OF OPERATION Diaphragmatic hernia. Gastric Ulcer, benign.		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) ---	(COUNTY) ---
TIME (Month) (Day) (Year) (Hour) OF INJURY ---	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? ---	

22. I hereby certify that I attended the deceased from **July 18**, 19**50**, to **Jan 23**, 19**51**, and that death occurred at **10:10 PM**, from the causes and on the date stated above.

SIGNATURE **E. P. BRANNON M.D.** (Degree or title) ADDRESS **Chief, Professional Services, VAH., Perry Point, Md.** DATE SIGNED **1-24-51**

23. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	DATE 1-24-51	NAME OF CEMETERY OR CREMATORY Holy Sepulcher Cemetery	LOCATION (City, town, or county) Chicago, Illinois.
DATE REC'D BY LOCAL REG. Jan 24/1951	REGISTRAR'S SIGNATURE Doreen E. Dougherty	FUNERAL DIRECTOR Pennington & Son, Havre De Grace, Md.	

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 26 1951
REAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 92

1. PLACE OF DEATH - COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Md.</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Water St.</u>		STREET ADDRESS (If rural, give location) <u>Water St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>HOWAR.</u> (Middle) <u>ELWOOD</u> (Last) <u>DAVIS</u>	4. DATE OF DEATH	(Month) <u>1</u> (Day) <u>31</u> (Year) <u>1951</u>
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>Widowed</u>	8. DATE OF BIRTH <u>2-16-1893</u>
9. AGE last birthday <u>57</u> yrs.		10. If under 1 year Months <u>6</u> Days <u>7</u>	11. If under 24 hrs. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Teaching</u>	
11. BIRTH PLACE (State or foreign country) <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Davis</u>		14. MOTHER'S MAIDEN NAME <u>Laura Powell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Ed Davis</u>	
17. INFORMANT <u>Ed Davis</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Diabetic coma.

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Dr. R. L. Dockson D.M.E. Rising Sun Md. 2-2-51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Feb 5 J. H. Trauger 24 W. Pippin & Son Elkton Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH: COUNTY <u>Cecil</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md.</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Union Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) <u>Annie</u> (Middle) <u>Morello</u> (Last) <u>Ewing</u>		4. DATE OF DEATH (Month) <u>Jan.</u> (Day) <u>26</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH (Month) <u>Aug.</u> (Day) <u>18</u> (Year) <u>1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Cecil Co. Md.</u>
13. FATHER'S NAME <u>John H. Kirkwood</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth McNamee</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		17. INFORMANT AND ADDRESS <u>George Ewing Rising Sun, Md.</u>	

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
<p>Immediate cause (a) <u>Emiplegia Left side</u></p> <p>Antecedent cause(s) (b) <u>Arterio sclerosis</u></p> <p>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)</p>	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-1, 1949, to 1-26, 1951, that I last saw the deceased alive on 1-26, 1951, and that death occurred at 1-15P. m., from the causes and on the date stated above.

SIGNATURE W. Woodson (Degree or title) ADDRESS Rising Sun Md. DATE SIGNED 1-26-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Jan. 30, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Bank Cem.</u>	LOCATION (City, town, or county) (State) <u>near Rising Sun Md.</u>
DATE REC'D BY LOCAL REG. <u>Jan 27</u>	REGISTRAR'S SIGNATURE <u>J. R. Trager</u>	24. FUNERAL DIRECTOR <u>J. Carl Tyson</u>	ADDRESS <u>Rising Sun, Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Calvert</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Calvert</u>	
TOWN <u>Calvert</u>		TOWN <u>Calvert</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Union Hospital</u>		STREET ADDRESS (If rural, give location) <u>Rising Sun R.D.</u>	
3. NAME OF DECEASED (First) <u>EUGENIA</u> (Middle) <u>H</u> (Last) <u>HALL</u>		4. DATE OF DEATH (Month) <u>1</u> (Day) <u>14</u> (Year) <u>1967</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>11-24-1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical nurse and was president</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Vasopneumonia</u>	9. AGE last birthday <u>62</u> yrs. <u>1</u> Months <u>21</u> Days <u>14</u> Hours <u>14</u> Min.
13. FATHER'S NAME <u>Samuel Harkne</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Thompson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>11-24-1888</u>	
17. INFORMANT AND ADDRESS <u>Ellis Harkne</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Strangulated Rt Inguinal Hernia</u>			
Antecedent cause(s) (b) <u>Shock & Paralytic ileus</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Shock & Paralytic ileus</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>1-10-51</u>		19b. MAJOR FINDINGS OF OPERATION <u>Release of Hernia</u>	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>11:10 P.M.</u>		HOW DID INJURY OCCUR? <u>While at Work</u>	

22. I hereby certify that I attended the deceased from 1-10, 1951, to 1-14, 1951, that I last saw the deceased alive on 1-14, 1951, and that death occurred at 11:10 P.M., from the causes and on the date stated above.

SIGNATURE W. L. Jackson, M.D. ADDRESS Rising Sun Md DATE SIGNED 1-14-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>1/18/51</u>	NAME OF CEMETERY OR CREMATORY <u>Friends Burial Ground</u>	LOCATION (City, town, or county) <u>Calvert Cecil Co. Md.</u>
DATE REC'D BY LOCAL REG. <u>Jan 15</u>	REGISTRAR'S SIGNATURE <u>W. L. Jackson</u>	24. FUNERAL DIRECTOR <u>William P. Johnston</u>	ADDRESS <u>222 Penn Ave</u>

MARGIN RESERVED FOR BINDING

VS. A15

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RECEIVED
JAN 10 1951

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE VIRGINIA COUNTY FAIRFAX	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Perry Point		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN CLIFTON	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital		STREET ADDRESS (If rural, give location) None	
3. NAME OF DECEASED (Type or Print) BERNARD N. HELFERT		4. DATE OF DEATH (Month) January (Day) 16 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Divorced	8. DATE OF BIRTH 11-8-95
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	9. AGE last birthday 55 yrs.
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) Yes WW I		16. SOCIAL SECURITY No. Unknown	
17. INFORMANT AND ADDRESS Hospital Records, VAH., Perry Point, Md.			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
420.1 Immediate cause (a) Coronary sclerosis, severe	Unknown	
Antecedent cause(s) (b) Myocardial infarction	Approx. 4 yrs	
94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Arteriosclerosis, generalized, severe	Unknown	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION --	19b. MAJOR FINDINGS OF OPERATION --	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY -- m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? --

22. I hereby certify that I ^{VA} attended the deceased from **Jan. 11, 1951**, to **Jan. 16, 1951**, that I last saw the deceased **alive on Jan. 11, 1951**, and that death occurred at **6:30 AM**, from the causes and on the date stated above.

SIGNATURE *[Signature]* (Degree or title) ADDRESS DATE SIGNED
E. P. BRANNON, M.D., Chief, Professional Services, VAH, Perry Point, Md. 1-17-51

23. BURIAL, CREMATION REMOVAL (Specify) REMOVAL	DATE 1-18-51	NAME OF CEMETERY OR CREMATORY Arlington National Cemetery, Fort Myer, Va.	LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REG. Jan 18, 1951	REGISTRAR'S SIGNATURE <i>[Signature]</i>	24. FUNERAL DIRECTOR PENNINGTON & SON, Havre de Grace, Md.	ADDRESS VVVVVVV

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

Reg. Dist. No. **96**

1. PLACE OF DEATH COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Perry Point		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration		STREET ADDRESS (If rural, give location) 403 Calhoun Street	
3. NAME OF DECEASED (Type or Print)	(First) ARTHUR (Middle) W. (Last) HENLEY	4. DATE OF DEATH (Month) January (Day) 10 (Year) 1951	
5. SEX male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Divorced	8. DATE OF BIRTH 4-12-1894
9. AGE last birthday 56 yrs.		10. BIRTHPLACE (State or foreign country) Hanover County, Virginia	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry Worker		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Unknown - deceased		14. MOTHER'S MAIDEN NAME Unknown - deceased	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-II		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital records			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause Strangulation by hanging	(a)	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 974X 164a		(b)
(c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input checked="" type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .	
SIGNATURE R. C. DODSON	DATE SIGNED Jan. 10, 1951
23. BURIAL, CREMATION, REMOVAL, (Specify) Removal	DATE THEREOF 1-10-51
NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery, Baltimore, Md.	
LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR PENNINGTON & SON, Havre de Grace, Md.	ADDRESS

VS. A15A

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

643 846

RECEIVED
JAN 17 1961
U.S. AIR FORCE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. **96**

1. PLACE OF DEATH- COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE District of Columbia COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Perry Point,		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital		STREET ADDRESS (If rural, give location) 6600 "H", N.E.,	
3. NAME OF DECEASED (Type or Print)	(First) LAWRENCE	(Middle) (NMI)	(Last) HICKS
4. DATE OF DEATH	(Month) January	(Day) 23	(Year) 19 51
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) divorced	8. DATE OF BIRTH March 8, 1887
9. AGE last birthday 63 yrs.		10. If under 1 year: Months 0 Days 0 Hours 0 Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Hicks - deceased		14. MOTHER'S MAIDEN NAME Nettie Beckwith - deceased	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-I		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT AND ADDRESS Hospital Records, VAH., Perry Point, Md.			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Uremia, uremic poisoning		2 weeks
Antecedent cause(s) (b) Pneumonia, bronchial, bilateral		4 days
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Nephrosis, bilateral severe		2 weeks

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION 1-18-51	19b. MAJOR FINDINGS OF OPERATION Same as above
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
(CITY OR TOWN)	(COUNTY)
(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **Jan. 5, 1951**, to **Jan. 23, 1951**, that he died on the date stated above, and that death occurred at **3:30 PM.**, from the causes and on the date stated above.

SIGNATURE **E. P. Pennington** (Degree or title) **Chief, Professional Services, VAH., Perry Point, Md.** ADDRESS **1-26-51**

23. BURIAL, CREMATION, REMOVAL (Specify) **REMOVAL** DATE THEREOF **Jan 26, 1951** NAME OF CEMETERY OR CREMATORY **Arlington National Cemetery** LOCATION (City, town, or county) **Fort Myer, Virginia.** (State)

DATE REC'D BY LOCAL REG. **Jan 26, 1951** REGISTRAR'S SIGNATURE **E. P. Pennington** ADDRESS **PENNINGTON & SON, Havre De Grace, Md.**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH- COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Pennsylvania COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Perry Point, Md.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Red Lion	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) (Middle) (Last) SIMON L. HOLMES		4. DATE OF DEATH (Month) (Day) (Year) January 5, 1951	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Divorced	8. DATE OF BIRTH 1-30-1887
9. AGE last birthday 63 yrs.		10. If under 1 year Months 11 Days 5	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor foreman- Aberdeen		11b. KIND OF BUSINESS OR INDUSTRY Prov. Gr.-Govt.	
11. BIRTHPLACE (State or foreign country) McCall's Ferry, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown - deceased		14. MOTHER'S MAIDEN NAME Unknown - deceased	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW-1		16. SOCIAL SECURITY No. Unknown	
17. INFORMANT AND ADDRESS Hospital Records			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Brain tumor, metastatic, primary site unknown, probably pulmonary

Unknown

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

12-18-50

19b. MAJOR FINDINGS OF OPERATION

Same as above

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/7/1950, to 1/5/1951, and that death occurred at 6:00 AM., from the causes and on the date stated above.

SIGNATURE
E. P. BRANNON, M.D., Chief, Professional Services, VAH, Perry Point, Md.

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)
Removal

DATE THEREOF

1-5-51

NAME OF CEMETERY OR CREMATORY

Pine Grove,

LOCATION (City, town, or county)

York County, Pa.

(State)

DATE REC'D BY LOCAL REG.

Jan. 5, 1951

REGISTRAR'S SIGNATURE

James E. Dougherty

24. FUNERAL DIRECTOR

Lee A. Patterson

ADDRESS

LEE A. PATTERSON & SON, PERRYVILLE, MD.

525 916 Per. Carl B. Bury & Son Red Lion Pa

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change
of age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

0493

FILE No. G 130 JAN 17 1951

Reg. Dist. No. 94

1. PLACE OF DEATH COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town) North East		CITY (If outside corporate limits, write RURAL and give nearest town) North East	
TOWN North East		TOWN North East	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) Susie (First) (Middle) JACKSON (Last)		4. DATE OF DEATH (Month) 1 (Day) 9 (Year) 1951	
5. SEX F.	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, SEPARATED	8. DATE OF BIRTH 2-29-1879
9. AGE last birthday 71 yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) North East Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Culley		14. MOTHER'S MAIDEN NAME Lidia Margaret Riley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No.	
17. INFORMANT Amory Jackson			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause Acute coronary thrombosis			
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing in the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
(CITY OR TOWN) (COUNTY) (STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE R. L. Dodson MD DMC		DATE SIGNED 1-9-51	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF 1-12-1951	
NAME OF CEMETERY OR CREMATORY Methodist		LOCATION (City, town, or county) North East Cecil Md	
DATE REC'D BY LOCAL REG Jan 12-51		24. FUNERAL DIRECTOR ADDRESS Joseph R. Grant North East Md	



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Port Deposit, Rural, 6 Mos.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) 1634 Wilmer Court	
3. NAME OF DECEASED (Type or Print) Albert Jones		4. DATE OF DEATH Jan. 19, 1951	
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 6-17-1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Day	9. AGE last birthday 67 yrs.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George W. Jones		14. MOTHER'S MAIDEN NAME Elizabeth Wilmer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS Elizabeth Smith, Port Deposit, Md.			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
331x Immediate cause (a)	Cerebral Hemorrhage -		7 days
Antecedent cause(s)	Paralysis right side -		
85a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	Arterio-Sclerosis -		8 yrs
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan 17, 1951, to Jan 19, 1951, that I last saw the deceased alive on Jan 19, 1951, and that death occurred at 8 A.M., from the causes and on the date stated above.

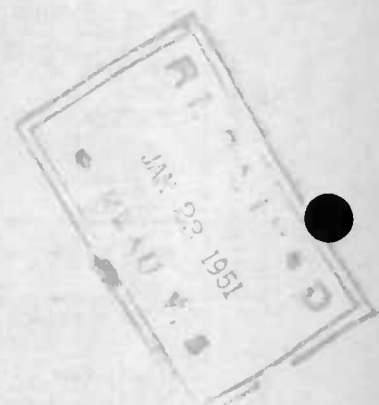
SIGNATURE B. J. Johnson, M.D. ADDRESS Port Deposit, Md. DATE SIGNED 1/20/51

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 1-22-1951	NAME OF CEMETERY OR CREMATORY Cokesbury	LOCATION (City, town, or county) (State) Port Deposit, Md, Rural
DATE REC'D BY LOCAL REG. Jan 22, 1951	REGISTRAR'S SIGNATURE Lrene E. Dougherty	24. FUNERAL DIRECTOR Perryville, Md.	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH- COUNTY <u>Cecil</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>ELKTON</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Union Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Cecil</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>North East Rural</u> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>William Jones</u> (First) <u>William</u> (Middle) <u>Jones</u> (Last)		4. DATE OF DEATH (Month) <u>1</u> (Day) <u>6</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>11-27-1875</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM OWNER</u>	9. AGE last birthday <u>75</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William Jones</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Bennett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Walter Preston North East Md</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Acute Coronary Thrombosis</u>	<u>1 day</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Myocardial Infarct</u>	<u>..?</u>
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from <u>Dec 30</u> , 19 <u>51</u> , to <u>Jan 6</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>Jan 6</u> , 19 <u>51</u> , and that death occurred at <u>6:45</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Joseph R. Grant</u>		ADDRESS <u>Elkton</u>	
DATE SIGNED <u>1/8/51</u>			
23. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>1-10-51</u>	NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>	LOCATION (City, town, or county) (State) <u>ELKTON RURAL Md</u>
DATE REC'D BY LOCAL REG. <u>Jan 9</u>	REGISTRAR'S SIGNATURE <u>J. R. Grant</u>	24. FUNERAL DIRECTOR <u>Joseph R. Grant North East Md</u>	

100105

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 12 1951
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0496 96

1. PLACE OF DEATH COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Perryville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Perryville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>Aikin Ave.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Velva</u> (Middle) <u>May</u> (Last) <u>Krauss</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 30, 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 20, 1906</u>
9. AGE last birthday <u>44</u> yrs.		10. If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Book Keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Warehouse</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert S. Stine</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Brannan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>217-14-9960</u>	
17. INFORMANT AND ADDRESS <u>Sherman S. Krauss, Perryville, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Cerebral Hemorrhage (Paralysis - Right Side)</u>		<u>4 1/2 hrs</u>	
Antecedent cause(s) (b) <u>Arterio-Sclerosis - Hypertension -</u>		<u>4 yrs</u> <u>4 yrs</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY)		(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?					

22. I hereby certify that I attended the deceased from March, 1949, to Jan 30, 1951, that I last saw the deceased alive on Jan 30, 1951, and that death occurred at 11:30 A.M., from the causes and on the date stated above.

SIGNATURE G. J. Johnson M.D. ADDRESS Port Deposit, Md DATE SIGNED 2/1/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>2-2-1951</u>		NAME OF CEMETERY OR CREMATORY <u>West Nottingham</u>		LOCATION (City, town, or county) <u>Colora, Md. Rural</u>		(State)	
DATE REC'D BY LOCAL REG. <u>Feb. 2, 1951</u>		REGISTRAR'S SIGNATURE <u>Irene E. Dougherty</u>		24. FUNERAL DIRECTOR <u>W. A. Patterson & Son</u>		ADDRESS <u>Perryville, Md.</u>			

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

000319

RECEIVED
FEB 5 1951
KODAK

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

0407

Reg. Dist. No. 96

1. PLACE OF DEATH- COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Wash.		
CITY (If outside corporate limits, write RURAL and give nearest town) Perry Point,			CITY (If outside corporate limits, write RURAL and give nearest town) Hagerstown		
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration			STREET ADDRESS (If rural, give location) 1138 Oak Hill Avenue		
3. NAME OF DECEASED (First) HENRY (Middle) R. (Last) KRITZER			4. DATE OF DEATH (Month) January (Day) 10, (Year) 1951		
5. SEX male			8. DATE OF BIRTH 8-15-1893		
6. COLOR OR RACE white			9. AGE last birthday 57 yrs. <input type="checkbox"/> If under 1 year <input type="checkbox"/> If under 24 hrs.		
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married			10. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician			11. BIRTHPLACE (State or foreign country) Richmond, Virginia		
10b. KIND OF BUSINESS OR INDUSTRY Private practice			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Unknown - deceased			14. MOTHER'S MAIDEN NAME Unknown - deceased		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service)			17. INFORMANT Hospital records		
16. SOCIAL SECURITY No. Unknown					

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) **Coronary occlusion**
 Antecedent cause(s) (b) **Coronary sclerosis**
 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) **Arteriosclerosis, generalized and cerebral Hemiplegia, moderately severe, residuals of**

INTERVAL BETWEEN ONSET AND DEATH

Unknown

11. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing in the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

20. AUTOPSY?

Yes ☐ No ☒

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

ADDRESS

DATE SIGNED

R. C. DODSON, M.D., D.M.E., Cecil County, Rising Sun, Maryland 1-10-51

23. BURIAL, CREMATION, REMOVAL (Specify) **Removal** DATE THEREOF **1-11-51** NAME OF CEMETERY OR CREMATORY **Rest Haven Cemetery,** LOCATION (City, town, or county) **Hagerstown, Maryland** (State)

DATE REC'D BY LOCAL REG. **Jan 11, 1951** REGISTRAR'S SIGNATURE **Lena S. Daugherty**

24. FUNERAL DIRECTOR **Andrew K. Coffman** ADDRESS **Hagerstown, Maryland**

ANDREW K. COFFMAN FUNERAL HOME, Hagerstown, Maryland

075868

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15A



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH- COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Harford	
CITY (If outside corporate limits, write RURAL and give nearest town) Perry Point		CITY (If outside corporate limits, write RURAL and give nearest town) Havre de Grace	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital		STREET ADDRESS (If rural, give location) 102 Seneca Avenue	
3. NAME OF DECEASED (Type or Print)	(First) HOWARD	(Middle) A.	(Last) LEISHMAN SR.
4. DATE OF DEATH	(Month) January	(Day) 5,	(Year) 1951
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 10-4-95
9. AGE last birthday 55 yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter Commercial		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Andrew Leishman (Deceased)		14. MOTHER'S MAIDEN NAME Mary Butler (Deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 138-10-1962	
17. INFORMANT AND ADDRESS Hospital Records, VAH, Perry Point, Md.			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause Carcinoma of the lung		Unk.
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
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21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 12-27, 1950, to 1-5, 1951, and that death occurred at 9:15 P. m., from the causes and on the date stated above.

SIGNATURE: *E.P. Pennington* (Degree or title) ADDRESS: *Chief Professional Services, VAH, Perry Point, Md.* DATE SIGNED: *Jan 5, 1951*

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Removal	1-5-51	Angel Hill Cemetery	Havre De Grace, Maryland

DATE REC'D BY LOCAL REG. Jan 5, 1951	REGISTRAR'S SIGNATURE <i>James E. Dougherty</i>	24. FUNERAL DIRECTOR <i>Pennington & Son</i> ADDRESS: <i>Pennington & Son, Havre de Grace, Md.</i>
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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

004899



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 94

1. PLACE OF DEATH- COUNTY <u>CECIL</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>CECIL</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>North East</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>ELKTON</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>MARGARETTA M.</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>1-14-1951</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>1-8-1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	9. AGE last birthday <u>78</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>ELKTON MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES T COLE</u>		14. MOTHER'S MAIDEN NAME <u>MARY DRENNEN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT <u>Mrs Herman Lockard</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
420.0 Immediate cause (a) <u>Coronary Occlusion</u>		<u>48 hours</u>
93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Arteriosclerotic Heart Disease</u>	<u>5 years</u>
	(c) <u>Bronchial Asthma</u>	<u>15 years?</u>

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Not While Work <input type="checkbox"/> At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

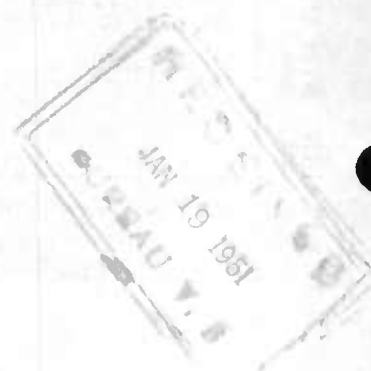
22. I hereby certify that I attended the deceased from Oct, 1950, to Jan, 1951, that I last saw the deceased
alive on 14 Jan, 1951, and that death occurred at 10 P m., from the causes and on the date stated above.

SIGNATURE Klaus H. Huchner M.D. ADDRESS North East, Md DATE SIGNED 17 Jan '51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>1-17-51</u>	NAME OF CEMETERY OR CREMATORY <u>Methodist</u>	LOCATION (City, town, or county) <u>North East, Md</u>	(State) <u>MD</u>
DATE REC'D BY LOCAL REG. <u>1-17-51</u>	REGISTRAR'S SIGNATURE <u>Sarah E. Kothermel</u>	24. FUNERAL DIRECTOR <u>Joseph P. Thoms North East, Md</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 95

1. PLACE OF DEATH- COUNTY <i>Cecil</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Maryland</i> COUNTY <i>Cecil</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Rising Sun Rural</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Rising Sun Rural</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <i>Romay</i> (Middle) <i>Lyell</i> (Last) <i>Lyell</i>	4. DATE OF DEATH (Month) (Day) (Year) <i>Jan. 9, 1951</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Feb. 17, 1886</i> 64 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (State or foreign country) <i>Wilkes Co. N. C.</i>
13. FATHER'S NAME <i>Wm. Lyell</i>		14. MOTHER'S MAIDEN NAME <i>Millie Larnall</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <i>204-07-5327</i>	
		17. INFORMANT AND ADDRESS <i>Mrs. Romay Lyell</i>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Uremia

INTERVAL BETWEEN ONSET AND DEATH

240 hrs

Antecedent cause(s)

(b)

Generalized Arteriosclerosis

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Cerebral Hemorrhage

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Jan. 9, 1948*, to *Jan. 9, 1951*, that I last saw the deceasedalive on *Jan. 9, 1951*, and that death occurred at *4 P. m.*, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Malcolm Studley Phillips MD *Darlington, Md**1/9/51*

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Jan 10 - 1951 *Edmund Huntington**H.B. Bailey* *Darlington, Md*

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0411 92

1. PLACE OF DEATH COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>	
TOWN <u>Elkton</u>		TOWN <u>North East</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Union Hospital, Elkton</u>		STREET ADDRESS (If rural give location) <u>✓</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Viola</u>	(Middle) <u>A</u>	(Last) <u>Lynch</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct 31 1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	9. AGE last birthday <u>71</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>North East, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Phillip</u>		14. MOTHER'S MAIDEN NAME <u>Mary Demond</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY No. <u>-</u>	
17. INFORMANT <u>J. Edward Lynch</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Uremia</u>	<u>6 wks</u>
Antecedent cause(s) (b) <u>Arteriosclerotic Cardiovascular Renal Disease</u>	<u>5 years</u>
(c) <u>Diabetes Mellitus</u>	<u>10 years</u>

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
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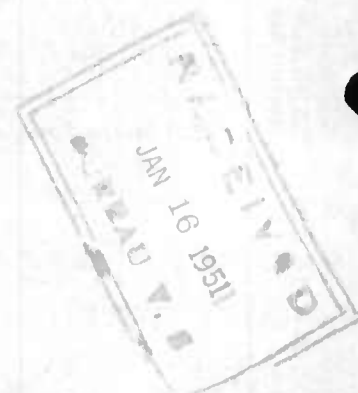
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
HOMICIDE	INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1946, to 11 Jan, 1951, that I last saw the deceased alive on 11 Jan, 1951, and that death occurred at 7 P. m., from the causes and on the date stated above.

SIGNATURE <u>Klaus H. Huchner</u>	(Degree or title) <u>M.D.</u>	ADDRESS <u>North East Md</u>	DATE SIGNED <u>13 Jan '51</u>
23. BURIAL, CREMATION REMOVAL, (Specify)	DATE THEREOF <u>1-14-51</u>	NAME OF CEMETERY OR CREMATORY <u>Methodist</u>	LOCATION (City, town, or county) (State) <u>North East Md</u>
DATE REC'D BY LOCAL REG. <u>Jan 13</u>	REGISTRAR'S SIGNATURE <u>J. H. Truax</u>	24. FUNERAL DIRECTOR <u>Joseph R. Grant</u>	ADDRESS <u>North East Md</u>

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH- COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE D.C. COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Perry Point		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration		STREET ADDRESS (If rural, give location) 4235 Silver Hill Road	
3. NAME OF DECEASED (First) LOUIS (Middle) - (Last) MACKLIN		4. DATE OF DEATH (Month) January (Day) 5, (Year) 1951	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 5-3-17
9. AGE last birthday 33 yrs.		10. CITIZEN OF WHAT COUNTRY? USA	
11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW-II		16. SOCIAL SECURITY No. Unknown	
17. INFORMANT AND ADDRESS Hospital records			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **Sarcoma, Reticulum Cell Type, with generalized**

INTERVAL BETWEEN ONSET AND DEATH

2 Months

Antecedent cause(s)

(b) **Metastasis**

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **Dec. 13, 1950**, to **Jan. 5, 1951**, that I last saw the deceased

and that death occurred at 1:12 PM m., from the causes and on the date stated above.

SIGNATURE **E. P. BRANNON** (Degree or title) ADDRESS **Washington, D.C.** DATE SIGNED **Jan. 6, 1951**

23. BURIAL, CREMATION REMOVAL (Specify) Removal		DATE THEREOF 1-6-51		NAME OF CEMETERY OR CREMATORY Unknown		LOCATION (City, town, or county) (State) Washington, D.C.	
DATE REC'D BY LOCAL REG. Jan. 6, 1951		REGISTRAR'S SIGNATURE Diana E. Langford		FUNERAL DIRECTOR PENNINGTON & SON		ADDRESS Havre de Grace, Md.	

PENNINGTON & SON, Havre de Grace, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH- COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town) Elkton		CITY (If outside corporate limits, write RURAL and give nearest town) Elkton	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 124 Milburn St.		STREET ADDRESS (If rural, give location) 124 Milburn St.	
3. NAME OF DECEASED (Type or Print)	(First) James	(Middle) Stanley	(Last) Matthews
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH May 6, 1950
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Elkton Maryland
13. FATHER'S NAME Roy Matthews		14. MOTHER'S MAIDEN NAME Margaret Williams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No. none	17. INFORMANT AND ADDRESS Roy Matthews 124 Milburn St. Elkton, Md.

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Pneumonia

Antecedent cause(s)

(b) Ductal ectasia

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

2 days

5 days

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased

alive on....., 19....., and that death occurred at.....m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2/1/51	Provident Cemetery	Elkton, Maryland
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb 1	H. Trauer	Edna Bell	909 Poplar St.

105060203401

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH- COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE District of Columbia COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Perry Point		CITY (If outside corporate limits, write RURAL and give nearest town) Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital		STREET ADDRESS (If rural, give location) 4018 Ninth Street, N. E.	
3. NAME OF DECEASED (First) FRANK (Middle) LEO (Last) MC ALEER		4. DATE (Month) (Day) (Year) OF DEATH January 1 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 4-17-87
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Govt. Guard		10b. KIND OF BUSINESS OR INDUSTRY Government	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Mc Aleer (Deceased)		14. MOTHER'S MAIDEN NAME Ellen Hearin (Deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT AND ADDRESS Hospital Records, VA Hospital, Perry Point Md			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause (c) Carcinoma, primary, head of pancreas with biliary obstruction and liver damage		Unknown
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis, generalized	
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19a. DATE OF OPERATION --	19b. MAJOR FINDINGS OF OPERATION --	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) --	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY --	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY --	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? --

22. I hereby certify that I attended the deceased from Nov. 28, 1950, to Jan. 1, 1951, that I last saw the deceased alive on Jan. 1, 1951, and that death occurred at 2:45 P.m., from the causes and on the date stated above.

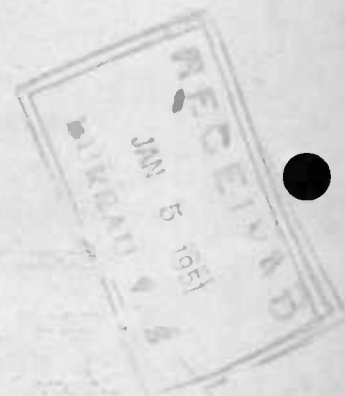
SIGNATURE W. OPPER, M.D., Actg. Chief, Professional Services, VAH, Perry Point, Md. Jan. 2, 1951		DATE SIGNED Jan. 2, 1951
23. BURIAL, CREMATION REMOVAL (Specify) Removal	DATE THEREOF Jan. 2, 1951	LOCATION (City, town, or county) Washington, D.C.
24. FUNERAL DIRECTOR S.H. HINES CO. 2901 14th St., Washington, D.C.	ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

763 916



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH- COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Perryville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Perryville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>William</u> (Middle) <u>S.</u> (Last) <u>Mc Cann</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 23, 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>2-9-1879</u>
9. AGE last birthday <u>71</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles McCann</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Hopkins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>James W. McCann, Perryville, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Cerebral Hemorrhage</u>		
Antecedent cause(s) (b) <u>Arterio Sclerosis</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Hypertension</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 24, 1950, to Jan 23, 1951, that I last saw the deceased alive on Jan 23, 1951, and that death occurred at 5:50 PM, from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE <u>1-25-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Dublin M.E.</u>	LOCATION (City, town, or county) <u>Dublin, Harford Co., Md.</u>
DATE REC'D BY LOCAL REG. <u>Jan 25, 1951</u>	REGISTRAR'S SIGNATURE <u>Irene E. Langley</u>	24. FUNERAL DIRECTOR <u>Lee A. Patterson & Son</u>	ADDRESS <u>Perryville, Md.</u>

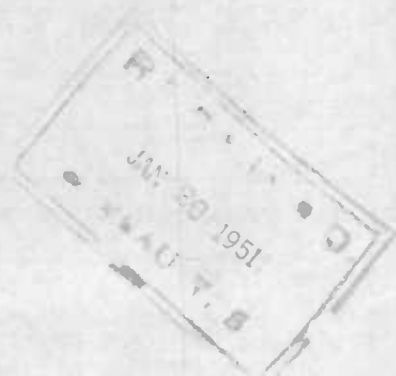
MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

0415

820105



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0415 92

Dr. Balle

1. PLACE OF DEATH- COUNTY <i>Cecil</i>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Md.</i> COUNTY <i>Cecil</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Elkton</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Elkton</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Union Hospital</i>				STREET ADDRESS <i>Water St.</i> (If rural give location)	
3. NAME OF DECEASED (Type or Print) <i>WILLIAM</i>		(First) (Middle) (Last) <i>McKane</i>		4. DATE OF DEATH <i>Jan 31, 1951</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>Wh.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>S.</i>	8. DATE OF BIRTH <i>Dec 24, 1878</i>	9. AGE last birthday <i>72</i> yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>James Walker</i>		14. MOTHER'S MAIDEN NAME <i>No Inf</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY No. (If year, give war or dates of service)		17. INFORMANT <i>Hospital Records, Elkton, Md.</i>	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
Immediate cause (a) <i>Acute cardiac dilatation</i>					
Antecedent cause(s) (b) <i>Local Pneumonia</i>				4 day	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <i>Cardio renal vascular disease</i>					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from....., 1947, to Jan 31, 1951, that I last saw the deceased alive on Jan 31, 1951, and that death occurred at 2 P. m., from the causes and on the date stated above.					
SIGNATURE <i>Herbert Balle - M.D.</i>		(Degree or title) <i>Elkton Md</i>		DATE SIGNED <i>Feb 1, 1951</i>	
23. BURIAL, CREMATION REMOVAL (Specify) <i>Removal</i>		DATE <i>Feb 5/51</i>		NAME OF CEMETERY OR CREMATORY <i>Elkton</i>	
LOCATION (City, town, or county) (State)		24. FUNERAL DIRECTOR <i>W. H. Kippner & Son</i>		ADDRESS <i>Elkton, Md.</i>	
DATE REC'D BY LOCAL REG. <i>Feb 5</i>		REGISTRAR'S SIGNATURE <i>J. K. S. Jager</i>			

VVVVVV

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

CERTIFICATE OF DEATH

RECEIVED
FEB 6 1951
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH- COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Perryville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Perryville</u>	
TOWN <u>Perryville</u>		TOWN <u>Perryville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Samuel</u> (First) <u>Owens</u> (Middle) <u>SMITH</u> (Last) <u>McMullen</u>		4. DATE OF DEATH <u>Jan. 3, 1951</u> (Month) (Day) (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Aug. 24, 1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baggage Clerk, Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penna. R R</u>	9. AGE last birthday <u>70</u> yrs. If under 1 year: Months Days Hours Mins.
13. FATHER'S NAME <u>Hazelett O. McMullen</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Norman McMullen, Perryville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Carcinoma of Esophagus</u>			<u>1 yr.</u>
Antecedent cause(s) (b) <u>150X</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>46a</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>		INJURY OCCURRED <u>White at Work</u> <input type="checkbox"/> <u>Not White At work</u> <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan. 1, 1951 to Jan 3, 1951, that I last saw the deceased alive on Jan. 1, 1951, and that death occurred at 8:00 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

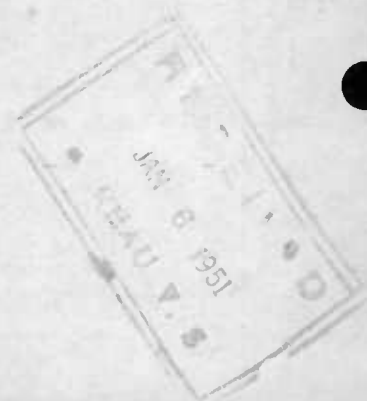
DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>1-6-1951</u>	NAME OF CEMETERY OR CREMATORY <u>St Marks</u>	LOCATION (City, town, or county) <u>Perryville, Md.</u> (State) <u>Rural</u>
DATE REC'D BY LOCAL REG. <u>Jan. 4, 1951</u>	REGISTRAR'S SIGNATURE <u>Irene E. Dougherty</u>	24. FUNERAL DIRECTOR <u>W. A. Patterson & Son</u> ADDRESS <u>Perryville, Md. 731506</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

0418

1. PLACE OF DEATH- COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY 101	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Perry Point, Md.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Chevy Chase	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration		STREET ADDRESS (If rural, give location) 6317 Connecticut Avenue	
3. NAME OF DECEASED (Type or Print) HERNDON (First) T. (Middle) MORSELL (Last)		4. DATE OF DEATH (Month) January (Day) 31 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Aug. 2, 1890
9. AGE last birthday 60 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
11. BIRTHPLACE (State or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? Massachusetts	
13. FATHER'S NAME Herndon Morsell		14. MOTHER'S MAIDEN NAME Lizzie Burton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war, or dates of service) Yes WW-1		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS Hospital Records			

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
<p>450.0 Immediate cause (a) Cirrhosis of Liver</p> <p>1242 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Anasarca</p> <p>(c) Arteriosclerosis</p>	Unknown

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MANNER OF DEATH
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **1-24-51**, 19**51**, to **1-31**, 19**51**, and that the cause of death was **Cirrhosis of Liver**, and that death occurred at **11:15 PM.**, from the causes and on the date stated above.

SIGNATURE **E. F. Brannon** (Degree or title) **Chief, Professional Services, VAH, Perry Point, Md.** ADDRESS **2-1-51** DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Removal	DATE THEREOF 2-2-51	NAME OF CEMETERY OR CREMATORY Glenwood Cemetery	LOCATION (City, town, or county) Washington, D. C.	(State)
DATE REC'D BY LOCAL REG. Feb. 2, 1951	REGISTRAR'S SIGNATURE Dwight E. Dougherty	FUNERAL DIRECTOR PENNINGTON & SONS		ADDRESS Havre de Grace, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH *pro*

2411 N. Charles Street, Baltimore

0419

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH- COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE MARYLAND COUNTY BALTIMORE	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Perry Point,		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN BALTIMORE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital		STREET ADDRESS (If rural, give location) 1808 Charles Street	
3. NAME OF DECEASED (Type or Print) RAYMOND (First) W (Middle) REYNOLDS (Last)		4. DATE OF DEATH January 16 1951 (Month) (Day) (Year)	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 6-5-1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	9. AGE last birthday 61 yrs. If under 1 year Months. Days Hours Min.
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) Yes WW-I		16. SOCIAL SECURITY No. Unknown	
17. INFORMANT AND ADDRESS Hospital Records, VAH., Perry Point, Md.			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a)	Coronary sclerosis, severe	Unknown
Antecedent cause(s) (b)	Myocardial infarction, old, multiple	Unknown
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)	Pancreatitis, acute, hemorrhagic	Approx. 36 hrs.
	Cholelithiasis, multiple	Unknown

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		18. MEDICAL CERTIFICATION	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **July 27**, 19**50**, to **Jan. 16**, 19**51**, the **causes of death** were **Coronary sclerosis, severe; Myocardial infarction, old, multiple; Pancreatitis, acute, hemorrhagic; Cholelithiasis, multiple**, and that death occurred at **7:30 AM**, from the causes and on the date stated above.

SIGNATURE **E. L. Brannon** (Degree or title) **Chief, Professional Services, VAH., Perry Point, Md.** DATE SIGNED **1-17-51**

23. BURIAL, CREMATION, REMOVAL DATE **Jan 16, 1951** NAME OF CEMETERY OR CREMATORY **Baltimore National Cemetery** LOCATION (City, town, or county) **Baltimore, Maryland** (State)

DATE REC'D BY LOCAL REG. **Jan 14, 1951** REGISTRAR'S SIGNATURE **James E. Dougherty** 24. FUNERAL DIRECTOR **Pennington & Son** ADDRESS **HAVRE DE GRACE, MD.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town) Elkton		CITY (If outside corporate limits, write RURAL and give nearest town) Rising Sun	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Union Hospital, Elkton, Md.		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)	(First) James (Middle) Clayton (Last) Richardson	4. DATE OF DEATH	(Month) Jan. (Day) 12 (Year) 1951
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Jan. 12, 1951
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday yrs. 3
11. FATHER'S NAME Ernest C. Richardson		12. CITIZEN OF WHAT COUNTRY USA	
13. MOTHER'S MAIDEN NAME Emma Tollenger		14. BIRTHPLACE (State or foreign country) Maryland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No. none	
17. INFORMANT Ernest C. Richardson		18. MEDICAL CERTIFICATION	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Respiratory Failure		
Antecedent cause(s) (b) collapse left lung.		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Breech Presentation		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-12, 1951, to 1-12, 1951, that I last saw the deceased alive on 1-12, 1951, and that death occurred at 2:30 p.m., from the causes and on the date stated above.

SIGNATURE Cecil Dockson MD ADDRESS Rising Sun, Md. DATE SIGNED 1-12-51

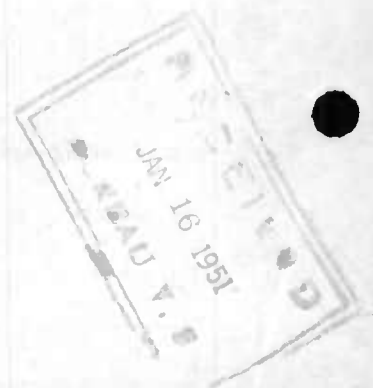
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 1/13/51	NAME OF CEMETERY OR CREMATORY Brookview	LOCATION (City, town, or county) Rising Sun, Md.
DATE REC'D BY LOCAL REG. Jan 13	REGISTRAR'S SIGNATURE H. L. Frazee	24. FUNERAL DIRECTOR Ralph M. Reed	ADDRESS Rising Sun, Md.

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 92

0421

1. PLACE OF DEATH - COUNTY <u>Becil</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Del.</u> COUNTY <u>Becil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Union Hosp.</u>		STREET ADDRESS (If rural, give location) <u>Newark R.D. Del.</u>	
3. NAME OF DECEASED (Type or Print) <u>Howard</u> (First) <u>Russell</u> (Last)		4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>3</u> (Year) <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>Oct. 14, 1879</u>
9. AGE last birthday <u>71</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Del.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>John Russell</u>		14. MOTHER'S MAIDEN NAME <u>no information</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY No. <u>Mrs. Alice J. Hall</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

about 1 yr.

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/12, 1950, to 1/3, 1957, that I last saw the deceased

alive on Jan 2, 1957, and that death occurred at 7:45 am, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

970116

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH - COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - COUNTY <u>MARYLAND</u> <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point,</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
TOWN <u>Perry Point,</u> LENGTH OF STAY (in this place) <u>19 yrs 6 mos 3 days</u>		TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>		STREET ADDRESS (If rural, give location) <u>814 Park Avenue</u> ✓	
3. NAME OF DECEASED (First) <u>WALTER</u> (Middle) <u>R.</u> (Last) <u>SHOEMAKER</u>	4. DATE OF DEATH (Month) <u>January</u> (Day) <u>5</u> (Year) <u>1951</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>3-28-1874</u>
9. AGE last birthday <u>76</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNKNOWN</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW-I</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Hospital Records, VAH, Perry Point, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Ulcer, gastric, hemorrhage massive

INTERVAL BETWEEN ONSET AND DEATH
Unk

Antecedent cause(s)

(b) Arteriosclerosis generalized, severe

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>---</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>---</u>		

22. I hereby certify that I attended the deceased from July 2, 1931, to Jan. 5, 1951, that I last saw the deceased alive on December 19, 1950, and that death occurred at 11:30 PM m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		DATE THEREOF <u>1-8-51</u>	NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery, Baltimore, Maryland</u>	LOCATION (City, town, or county) <u>Baltimore, Maryland</u>	(State)
DATE REC'D BY LOCAL REG. <u>Jan 8, 1951</u>		REGISTRAR'S SIGNATURE <u>Frank E. Pennington</u>	24. FUNERAL DIRECTOR <u>Pennington & Son</u>		
ADDRESS <u>Havre De Grace, Md.</u>					

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0423

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH- COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Pennsylvania COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Perry Point		CITY (If outside corporate limits, write RURAL and give nearest town) 48 First Street	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration		STREET ADDRESS (If rural, give location) Leetsdale	
3. NAME OF DECEASED (First) JOHN (Middle) C. (Last) SHUBAR		4. DATE OF DEATH (Month) Jan. (Day) 15, (Year) 19 51	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 6-24-1891
9. AGE last birthday 59 yrs. If under 1 year Months 8 Days 21 Hours Min. 		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner	
11. BIRTHPLACE (State or foreign country) Yugoslavia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Shubar - deceased		14. MOTHER'S MAIDEN NAME Barbara Klopowich - deceased	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW-I		16. SOCIAL SECURITY No. Unknown	
17. INFORMANT AND ADDRESS Hospital records			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **Carcinoma of the prostate, with metastases to the regional lymph nodes**

INTERVAL BETWEEN ONSET AND DEATH

Unknown

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) **Cirrhosis of the liver**(c) **Encephalomacia**

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **10-30-1945**, to **1-15-1951**, that I last saw the deceasedand that death occurred at **2:15 AM**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

S. P. BRANNON, M.D., Chief, Professional Services, VAH, Perry Point, Md. Jan. 16, 1951

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

Jan. 16, 1951**Irma E. Dougherty****PENNINGTON & SON****Havre de Grace, Md.****650216**

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH- COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Perry Point		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital		STREET ADDRESS (If rural, give location) 416 East 21st Street	
3. NAME OF DECEASED (Type or Print) JOHN A. SPRIGGS		4. DATE OF DEATH (Month) January 7 (Day) 51 (Year) 1951	
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 1-22-95
9. AGE last birthday 55 yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME John Spriggs (Deceased)		14. MOTHER'S MAIDEN NAME Sarah Brooks (Deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown	
(If yes, give year or dates of service) WW I		17. INFORMANT AND ADDRESS Hospital Records, VAH, Perry Point, Md.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Hypertensive cardiovascular disease		Unknown
Antecedent cause(s) (b) Syphilis, tertiary, with CNS involvement		Unknown
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Uremia		Unknown

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION --	19b. MAJOR FINDINGS OF OPERATION --	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE --	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY --	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY -- m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? --

22. I hereby certify that ~~VA~~ attended the deceased from 1-3....., 1951, to 1-7-....., 1951, that I last saw the deceased and that death occurred at 6:45 A.M., from the causes and on the date stated above.

SIGNATURE <i>E.P. Brannon</i>		ADDRESS		DATE SIGNED
E.P. BRANNON, M.D., Chief, Professional Services, VAH, Perry Point, Md.		Jan. 7, 1950		
23. BURIAL, CREMATION REMOVAL (Specify) Removal	DATE THEREOF 1-8-51	NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery, Baltimore, Md.	LOCATION (City, town, or county)	(State)
DATE REC'D BY LOCAL REG. Jan. 8, 1951	REGISTRAR'S SIGNATURE <i>June E. [illegible]</i>	24. FUNERAL DIRECTOR <i>Mrs. Samuel T. Hemsley</i>	ADDRESS 578 W. Biddle St. Mrs. Samuel T. Hemsley, Baltimore, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md.</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Eikton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Union Hospital</u>		STREET ADDRESS (If rural, give location) <u>Union Hospital</u>	
3. NAME OF DECEASED (Type or Print) <u>Mary F Stebbing</u>		4. DATE OF DEATH <u>Jan 4 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Sept 20 1878</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>72</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
13. FATHER'S NAME <u>Samuel Shank</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Brown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Wae Keane, North East, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
570.5 Immediate cause		(a) <u>Intestinal Obstruction</u>	
Antecedent cause(s)		(b) <u>Intestinal Adhesions -</u>	
128 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c) <u>Acute Pancreatitis.</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
12/6/30 - <u>Refused</u>		1/2/31 - <u>Intestinal obstruction</u>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Dec 5, 1956, to Jan 4, 1957, that I last saw the deceased alive on Jan 4, 1957, and that death occurred at 4 p.m., from the causes and on the date stated above.

SIGNATURE <u>Arthur Pennington</u>		ADDRESS <u>North East Maryland</u>		DATE SIGNED <u>Jan 4 57</u>
23. BURIAL CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Jan 8</u>	<u>Hopewell Cemetery</u>	<u>Port Deposit</u>	<u>md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS		
<u>Jan 4</u>	<u>F. H. Frazer</u>	<u>Lee & Patterson & Son</u> <u>Permyville, Md.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH- COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Perry Point</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>		STREET ADDRESS (If rural, give location) <u>9908 Merwood Lane</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>CLARENCE</u> (Middle) <u>ARTHUR</u> (Last) <u>TUDGE</u>		4. DATE OF DEATH (Month) <u>Jan.</u> (Day) <u>16</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>5-9-92</u>
9. AGE last birthday <u>58</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unk/</u>
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Arthur Tudge (Deceased)</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Weigle</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY No. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Hospital Records, VAH, Perry Point, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Hemorrhage, cerebral
due to

INTERVAL BETWEEN ONSET AND DEATH

3 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(b) Hypertensive cardiovascular renal disease

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 29, 1950 to Jan. 16, 1951, ~~and that death occurred at~~and that death occurred at 4:50 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

E. P. BRANNON, M.D., Chief, Professional Services, VAH, Perry Point, Md. Jan. 17, 1951

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Removal1-17-51UnknownUnknown

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

Jan 17, 1951Irma E. LaughlinPennington & Son600 N. VV PENNINGTON & SON, Havre de Grace, Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 92

1. PLACE OF DEATH COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Union Hospital</u>		STREET ADDRESS (If rural, give location) <u>135 Hollingnorth Manor.</u>	
3. NAME OF DECEASED (Type or Print) <u>JAMES LEROY</u> (First) (Middle) (Last)		4. DATE OF DEATH <u>Jan. 12</u> 19 <u>57</u> (Month) (Day) (Year)	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>Married</u>	8. DATE OF BIRTH <u>12-16-1898</u> 55 yrs. (Month) (Day) (Year)
10a. USUAL OCCUPATION (Specify end of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Building</u>	
11. BIRTHPLACE (State or foreign country) <u>Chromie, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles L. Ward.</u>		14. MOTHER'S MAIDEN NAME <u>Gertrude Payson.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Chas L Ward.</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

812.5 Immediate cause

(a) Shock, Internal Hemorrhage.

170c

Antecedent cause(s)

Disease or condition, if any, giving rise to the above cause, stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing in the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

PLACE (Home, farm, factory, street, etc.) OF INJURY Route 40

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY 1 11 51. 5:30

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR?

Was hit by truck

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Dr. R. E. Dodson D.M.E. Pottomac, Md. 1-13-57

23. BURIAL, CREMATION OR REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Jan 13

IR. L. L. L.

Joseph Grant

510246

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A



MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. **96**

1. PLACE OF DEATH- COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Perry Point, Maryland		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN TOWSON	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration		STREET ADDRESS (If rural, give location) Providence Road	
3. NAME OF DECEASED (Type or Print)	(First) NORMAN	(Middle) L.	(Last) WASTLER
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 2-12-33
9. AGE last birthday 17 yrs.		4. DATE OF DEATH January 21 1951	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sailor		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lloyd J. Wastler		14. MOTHER'S MAIDEN NAME Beulah Euerngam	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records, VAH., Perry Point, Md.			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<p>(1) Traumatic shock, severe; (2) Edema of the lungs, bilateral, severe. (3) Hemorrhage, retroperitoneal due to multiple fracture of pelvis. (4) Hemorrhage, avulsion right thigh. (5) Fracture of right femur. (6) Compound fracture of left tibia and fibula.</p>		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION 1-20-51	19b. MAJOR FINDINGS OF OPERATION as stated above	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> PLACE (Home, farm, factory, street, office, etc.) Route #40		(CITY OR TOWN) North East, RD., Cecil County, Maryland
TIME (Month) (Day) (Year) (Hour) OF INJURY Jan. 20, 1951 12:05 PM		HOW DID INJURY OCCUR? Truck Accident

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE *R. C. Dodson* Medical Examiner, Rising Sun, Maryland DATE SIGNED **1-21-51**

23. BURIAL, CREMATION REMOVAL (Specify) REMOVAL	DATE THEREOF 1-23-51	NAME OF CEMETERY OR CREMATORY Moreland Memorial Park	LOCATION (City, town, or county) (State) Baltimore, Maryland
DATE REC'D BY LOCAL REG. Jan. 23, 1951	REGISTRAR'S SIGNATURE <i>Irma E. Langford</i>	24. FUNERAL DIRECTOR <i>Pennington & Son</i>	ADDRESS PENNINGTON & SON, HAVRE DE GRACE, MD.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15A

970 916



MARYLAND STATE DEPARTMENT OF HEALTH ⁸⁰CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 042

1. PLACE OF DEATH- COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Ind.</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Perryville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Susquehanna River</u>		STREET ADDRESS (If rural, give location) <u>Narrington Apt.</u>	
3. NAME OF DECEASED (Type or Print) <u>John</u> (First) <u>Harlan</u> (Middle) <u>Williams</u> (Last)		4. DATE OF DEATH <u>1</u> (Month) <u>4</u> (Day) <u>1958</u> (Year)	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>Married</u>	8. DATE OF BIRTH <u>July-4-1897</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	9. AGE last birthday <u>53</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Bellair Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Howard F. Williams</u>		14. MOTHER'S MAIDEN NAME <u>Mary Swindell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give year or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>218-05-5898</u>	
17. INFORMANT <u>Robert T. Keaton (Bell)</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Drowned.</u>			
850. 8 Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>172</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing in the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> PLACE OF INJURY <u>Home, farm, factory, street, office, public place, etc.</u> (CITY OR TOWN) <u>Perryville</u> (COUNTY) <u>Cecil</u> (STATE) <u>Md.</u>			
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>1</u> <u>4</u> <u>50</u> <u>30</u> m.		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> HOW DID INJURY OCCUR? <u>Fell from Boat.</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <u>A. LeDachon MD DME</u> (Degree or title)		ADDRESS <u>Ring Sun. Md.</u> DATE SIGNED <u>1-5-58</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>1-6-58</u>	
NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>		LOCATION (City, town, or county) <u>Belle Md.</u> (State)	
DATE REC'D BY LOCAL REG. <u>1/5/58</u>		REGISTRAR'S SIGNATURE <u>W. Keaton</u>	
24. FUNERAL DIRECTOR <u>Stewart Monro</u>		ADDRESS <u>Belle Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.